Health care reform: the global search for Utopia

No single resolution is likely to work everywhere

Health care reform is rapidly becoming a global epidemic. President Clinton has just announced his plans for dealing with America's twin problems of inadequate coverage and escalating expenditure. Sweden, so long held out as having an exemplary system, is considering various new models.[1] Meanwhile, Britain is still digesting the consequences of the reforms of 1989. Almost everywhere, governments are grappling with the challenge of how best to meet increasing demands on health care systems while also trying to limit the demands on their budget.

Given this it is tempting to assume that a shared problem must have a shared solution: that there must be some ideal model of health care financing and organisation which, if only applied universally, would yield universal satisfaction. Hence the interest aroused by a report from National Economic Research Associates (NERA)—an international consultancy firm—which puts forward precisely such a model.[2,3]

Its solution lies in competitive health markets—an idea which has much influenced the American health care debate. But, the report argues further, the model has general applicability, even though its introduction may have to take account of the specific circumstances of individual countries: the report provides an ingenious guide to how it might be adapted, step by step, for British consumption.[4] Given that American ideas have had a considerable role in shaping policy in Britain—largely through Alain Enthoven's work[5]—it may therefore be as well to resist the impulse to ignore NERA's report, an impulse that may be reinforced by the knowledge that the study was funded by pharmaceutical firms and puts much emphasis on the implications of its approach for that industry.

The basic features of the NERA's model are simple. There would be universal comprehensive coverage for a guaranteed health care package provided through competing private insurance schemes. Insurers would have to accept all comers. Premiums related to income would be collected by a central fund, which would then make capitation payments to the insurance schemes related to the risk profile of their subscribers. In addition, individual people would pay premiums related to their risk to the insurance scheme of their choice, but only risks associated with personal behaviour (presumably smoking) would be taken into account. Lastly, copayments—that is, charges—would be mandatory for all services within the guaranteed health care package.

It is a seductive model. It seems to offer something to everyone. It guarantees universal access to health care. It promises, in Britain's case, an infusion of extra money into health care. It purports to ensure that resources will be used efficiently as a result of the competition between insurers and between providers. And it offers the pharmaceutical industry "a reduction in the government's incentives to control the prices and supply of medicines, as health care is no longer the dominant drain on the national budget."

It sounds too good to be true, and it is. Almost every assumption built into the model can be challenged. To start with, it depends on defining the guaranteed health care package—that is, the list of services that every insurance scheme must cover. Yet, as the report acknowledges, no country has yet designed such a package and it is difficult to see how it could be defined, given that changing technology is constantly redefining what medicine can do. Similarly, it assumes that competition between insurers and providers will automatically bring about efficiency in defiance of the evidence: one of the characteristics of health care is precisely that the conditions required for true competition in the marketplace (such as the ability of consumers to judge the product) are extraordinarily difficult to achieve. There is little evidence that charges will induce a more considered use of health services by consumers. They are socially inequitable and may be a deterrent to seeking early treatment.

The model is versatile. For countries like the United States it promises to control the cost explosion. For countries like Britain it promises to bring more money into the system. Such versatility may, in itself, give cause for scepticism. But, suspending disbelief, let us examine the case for thinking that NERA's model would solve the financial problems of health care in Britain. Instead of the NHS's budget being constrained by the government's determination to put a brake on the rise of public expenditure, runs the argument, the floodgates of finance will open as funding is devolved to the insurers. This is fool's gold. No government anywhere can ignore the cost of health care, whatever the method of finance. Whether health care is financed through taxes or insurance contributions related to income, there are obvious implications for the management of the economy and for employment. Here the United States surely offers the clinching argument. President Clinton is putting his head on the block over health care reform not because public spending is high (only 40% of all American health expenditure is publicly funded) but because the American people are worried about the rising cost of insurance and incomplete coverage, and American industry is worried about the resulting high labour costs. The notion that governments will give free rein to insurance premiums is simply not credible.

Almost certainly the question of health care finance and organisation will be back on the British political agenda within the next decade. The current round of reforms did not address the problems of finance; nor, contrary to political rhetoric, have they enhanced consumer choice. And when the debate starts up again the case for moving to an insurance based system will, rightly, be among the options to be considered. By then more evidence will be available from other countries about how different models are working.

In the meantime, though, it is important to distinguish between peddling panaceas and finding solutions to complex problems, which involve carefully weighing the trade off between different and perhaps conflicting policy objectives. President Clinton's plan represents an attempt to adapt the US's existing institutions of health care funding and organisation within the constraints of political and fiscal feasibility. Future changes in Britain—like past ones—are likely to show the same incremental, adaptive pattern rather than a plunge into a delusory Utopia.

RUDOLF KLEIN
Professor of social policy

Centre for the Analysis of Social Policy,
University of Bath,
Bath BA2 7AY

1 *Three models for health care reform in Sweden. A report from the expert group to the committee on funding and organisation of health services and medical care.* Stockholm: Ministry of Health and Social Affairs, 1993.
2 National Economic Research Associates. *Financing health care with particular reference to medicines.* Vol 1. *Summary and overview.* London: NERA, 1993.
3 Appleby A. Economists warn of gap in health care funding. *BMJ* 1993;**307**:755.
4 National Economic Research Associates. *Financing health care with particular reference to medicines.* Vol 13. *The health care system in the United Kingdom.* London: NERA, 1993.
5 Enthoven AC. *Reflections on the management of the National Health Service.* London: Nuffield Provincial Hospitals Trust, 1985.